ADVANCED ENDOCRINOLOGY & DIABETES CENTER PC- HISTORY & PHYSICAL **DATE**

NAME ☐ M ☐ F Marital Status S M W D SEP DATE OF BIRTH

ADDRESS PHONE (H) (O)

OCCUPATION/EMPLOYER REFERRED BY

1) How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2) Main reason for today's visit:

3) Other concerns I would like to discuss if there is time:

CHIEF COMPLAINT & H.P.I.

HABITS	CIG	PKG/ DAY	#YRS	PACK YRS	QUIT SMOKING	ALCOHOL	OZ/ WK	COFFEE	CUPS/ DAY	REG EXERCISE	STREET DRUGS

MEDICATIONS (DOSAGE/FREQ)		HOSPITAL	YEAR	REASON	YEAR	REASON
1.	5.					
2.	6.					
3.	7.					
4.	8.					
	9.					

FAMILY Hx						#	RELATIVE	#	RELATIVE
1) DIABETES ☐	6) STROKE ☐	11) C.A.D. ☐	16) COLITIS / CROHNS ☐						
2) THYROID DIS ☐	7) ALCOHOLISM ☐	12) HYPERTENSION ☐	17) KIDNEY DISEASE ☐						
3) METABOLIC DIS ☐	8) BLEED DIATH ☐	13) HAY FEVER ☐	18) ATHRITIS ☐						
4) EPILEPSY ☐	9) ANEMIA ☐	14) ASTHMA ☐	19) CANCER ☐						

Past Medical History

1) EENT	Hearing ☐	Vertigo ☐			
2) RESP	SOB ☐	Bronchitis ☐	Asthma ☐		
3) C.VASC.	HBP ☐	CAHD ☐	CHF ☐	Heart Murmur ☐	Arryth. ☐
4) G.I.	Esoph. Dis. ☐	PUD ☐	Hepat/Jaund. ☐		
5) P.VASC.	Int. Claud. ☐				
6) ONC./HEM	Cancer ☐	Anemia ☐	Bld. Diath. ☐		
7) G.U.	UTI ☐	Bladder ☐	Kidney ☐		
8) NEURO	Migraine ☐	Seizures ☐	Stroke ☐	Parkinsons ☐	
9) ARTH.	Arthralgia ☐	Gout ☐			
10) DERM.	Hives ☐	Eczema ☐			
11) MENT. ILL	Anorexia ☐	Depression ☐	Sleep Disorder ☐	Anxiety ☐	
12) INFECT.	TB ☐	Mono ☐	Rheum. Fever ☐		
13) FEMALES	# Preg.	LMP	Birth Control ☐	Menorrhea ☐	Mammogram
14) ENDOCRINE	Diabetes ☐	Thyroid ☐	Adrenal ☐		
15) OTHER	☐	☐	☐	☐	☐

ALLERGIES

OTHER/MISC.